Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Prevymis - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the request for Prevymis for prophylaxis of cytomegalovirus (CMV) infection or disease in hematopoietic stem cell transplant (HSCT)? If YES, go to 2. If NO, go to 4.

☐ Yes ☐ No

Q2. Is the patient CMV-seropositive?

☐ Yes ☐ No

Q3. Is the patient a recipient of an allogeneic HSCT?

☐ Yes ☐ No

Q4. Is the request for Prevymis for prophylaxis of CMV disease in kidney transplant?

☐ Yes ☐ No

Q5. Is the patient CMV-seronegative?

☐ Yes ☐ No

Q6. Is the patient a high-risk recipient of kidney transplant where donor is CMV seropositive?

Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Prevymis - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**

☐ Yes	☐ No
Q7. Requested Duration: ☐ 7 Months	☐ Other:
Q8. Additional Information:	

Prescriber Signature _____ Date _____

v2025